



Patient Intake Form

Name _____

E-mail Address _____

Present Health Concerns: Please list your most important health concerns in order of their significance.

1. _____ Approx. Date of Onset: _____

Does it interfere with your: Work Sleep Daily routine Recreation

Other therapies tried: Medications Surgery Chiropractic Physical therapy Other _____

2. _____ Approx. Date of Onset: _____

Does it interfere with your: Work Sleep Daily routine Recreation

Other therapies tried: Medications Surgery Chiropractic Physical therapy Other _____

3. _____ Approx. Date of Onset: _____

Does it interfere with your: Work Sleep Daily routine Recreation

Other therapies tried: Medications Surgery Chiropractic Physical therapy Other _____

Please list all **medications** that you are currently taking (or have used in the past two months), w/ dosages:

1. _____

4. _____

2. _____

5. _____

3. _____

6. _____

Please list any **vitamins, minerals, herbs, or homeopathic remedies** that you are presently taking:

1. _____

4. _____

2. _____

5. _____

3. _____

6. _____

Please list **allergies** that you have to any of the following:

Drugs: _____ Foods: _____

Other (ie pollen, dust, paint, ect.): _____

Health History

Past Medical History: Please list past injuries, broken bones, surgeries and hospitalizations, w/ approx dates.

Family Information:

Do you have children? Yes No If Yes, how many? _____ Ages _____

Are you, or could you be currently pregnant ? Yes No Due date _____

Please check if you have had (in the **last three months**)

GENERAL

- | | | |
|--|---|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Changes in appetite |
| <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Localized weakness |
| <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Tremors | <input type="checkbox"/> Poor sleeping |
| <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Cravings | <input type="checkbox"/> Peculiar tastes |
| <input type="checkbox"/> Bleed/bruise easily | <input type="checkbox"/> Sudden energy drop (time?) | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Heavy sleeping | <input type="checkbox"/> Dream disturbed sleep | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Dizziness | | |

HEAD, EYES, EARS, NOSE, AND THROAT

- | | | |
|---|--|---|
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> Earaches/Infections | <input type="checkbox"/> Sores on lips/tongue |
| <input type="checkbox"/> Eye strain/pain | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Excessive saliva |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Teeth problems |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Post nasal drip | <input type="checkbox"/> Gum problems |
| <input type="checkbox"/> Excessive tearing | <input type="checkbox"/> Excessive phlegm-Color? | <input type="checkbox"/> Headaches (location, triggers) |
| <input type="checkbox"/> Poor/blurry vision | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> TMJ Disorder |
| <input type="checkbox"/> Cataracts/Glaucoma | | |

SKIN AND HAIR

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Rashes/Hives | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Fungal infections/tinea |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Change in hair or skin texture |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Pimples/Acne | |

Other hair or skin concerns:

CARDIOVASCULAR

- | | | |
|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Fainting | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Swelling of hands | |

GASTROINTESTINAL

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Belching | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Itchy anus |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Burning anus |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Black stools | <input type="checkbox"/> Hemorrhoids/fissures |
| <input type="checkbox"/> Gas/bloating | <input type="checkbox"/> Mucus in stools | |
| <input type="checkbox"/> Hiccups | <input type="checkbox"/> Acid regurgitation | |
- History of chronic laxative use?

Other concerns with your general digestion:

GENTIO-URINARY

- | | | |
|---|---|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Nocturnal emissions |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Frequent urinary tract infections |
| <input type="checkbox"/> Decrease in flow | | |
- If you wake to urinate, how often?

Other concerns with genitals or urinary system:

MUSCULOSKELETAL

- | | | |
|--|---|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Cramps/spasms | <input type="checkbox"/> Foot/ankle pain |
| <input type="checkbox"/> Lower back pain | <input type="checkbox"/> General joint pain/stiffness | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Joint with limited range of motion _____ |
| <input type="checkbox"/> Muscle pains | | |

Other muscle, joint or bone concerns:

RESPIRATORY

- | | | |
|---|--|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Tight chest |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Pain w/ deep breath | <input type="checkbox"/> Production of phlegm-color? _____ Is it thick or thin? |
| <input type="checkbox"/> Asthma | | |

Other lung related concerns:

NEUROPSYCHOLOGICAL

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Irritability, anger |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Concussion | <input type="checkbox"/> Easily susceptible to stress |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Depression | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Tics | <input type="checkbox"/> Anxiety | <input type="checkbox"/> History of sexual/emotional or physical abuse |
| <input type="checkbox"/> Lack of coordination | | |

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Other neurological or psychological concerns:

Woman:

At what age did you start menstruating? _____ Number of days between cycles? _____

Duration of flow _____ Color _____ Clots? _____ Consistency of blood _____

Age of Menopause _____ Any bleeding since? _____

(Peri) Menopausal Symptoms: _____

Check any current symptoms:

- | | | |
|---|---|--|
| <input type="checkbox"/> Irregular menses | <input type="checkbox"/> Spotting between menses | <input type="checkbox"/> Discomfort/pain <i>during</i> menses |
| <input type="checkbox"/> Heavy flow | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Discomfort/pain <i>immediately following</i> menses |
| <input type="checkbox"/> Light flow | <input type="checkbox"/> Vaginal itching/burning | <input type="checkbox"/> Pelvic inflammatory disease |
| <input type="checkbox"/> No flow | <input type="checkbox"/> Discomfort/pain <i>before</i> menses | <input type="checkbox"/> Chronic yeast infections |
| <input type="checkbox"/> Polycystic ovaries/cysts | | |

PMS symptoms: _____

Any vaginal discharge? Yes No Amount _____ Color _____ Frequency _____

Number of Pregnancies _____ Deliveries _____ Abortions/Miscarriage(s) _____

Date of last PAP: _____ Results were: normal abnormal unsure

If you use birth control, what type & for how long?

Other gynecological concerns:

Men: check any current symptoms

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Lump in testicles | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Pain/itching of genitalia | <input type="checkbox"/> Penis blood/mucus discharge |

FAMILY HISTORY

Please fill in the boxes for each condition that applies to one of your family members.

	YES	WHO	Comments
Addiction (alcohol/drugs)			
Cancer			
Cardiac disorders (heart disease, high blood pressure, stroke)			
Diabetes			
Digestive/Gastro-intestinal disorders			
Immune disorders (hepatitis, HIV, etc.)			
Mental illness			
Respiratory disorders (asthma, allergies, etc)			
Skin disorders (eczema, Psoriasis, ect.)			
Seizure disorders			
Other			

COMMENTS

Please let us know of any other concerns you would like to address: